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PUBLIC AFFAIRS PAMPHLET No. 186

WHAT WE CAN DO ABOUT THE DRUG MENACE

BY ALBERT DEUTSCH

ABOUT THE DRUG MENACE, the new Public Affairs Pamphlet by the well-known writer, Albert Deutsch, is a booklet that should be read by all who want a balanced and thorough analysis of the narcotics problem today.

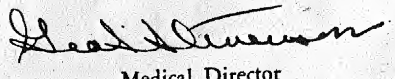
While there has been considerable increase in narcotic traffic since World War II, there is no "national epidemic." Of nearly 60 thousand addicts, only one-sixth are teen-agers, most of whom are found in a few big cities—New York, Chicago, Philadelphia, Baltimore, Detroit, Washington and New Orleans. Despite population increases, there are still fewer than half the addicts and one-fourth the teen-age addicts than were to be found in the country forty years ago.

The ineffectiveness of international controls no doubt has had something to do with the recent postwar upsurge, and of course it is true that if fewer narcotics were available, there would be fewer addicts. But the real problem, which is common to all juvenile delinquency, is more deepseated than this.

The great majority of teen-age addicts come from minority groups living in slum areas where life is bleak. These are the deprived people of our population and whether through narcotics or sexual promiscuity they are seeking a human relationship which their home and neighborhood has denied them.

The use of narcotics is a symptom of rebellion—against discrimination, futility and frustration. It is one of the more dangerous forms of rebellion because it is infectious. Teen-age addicts create more addicts because they are at an age that is particularly susceptible to "gang" motivation.

It is a disease that can be spread from the slums to those who for other than economic reasons have suffered deprivation, but fortunately the standard of living and satisfactions of family life are still great enough to guard against a widespread epidemic of this sort.



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WHAT WE CAN DO ABOUT THE DRUG MENACE

By ALBERT DEUTSCH

THE members of the U. S. Senate Crime Investigating Committee listened tensely as a strange succession of witnesses took the stand and told their stories. These were of a different breed than the big wheels of the syndicated rackets who had occupied the Committee's witness stand earlier. Now the Senators were listening to a tale of narcotic contagion that had set the nation on its ears—a tale told by the victims themselves. Most of these witnesses were teen-agers or barely out of their teens. The stories they told meshed in a common pattern—a pattern of personal deterioration that usually had its start when curiosity encountered temptation and succumbed, that quickly progressed to addiction and a descent into thievery or prostitution to obtain the money needed to obtain the addicting drug, then to apprehension, imprisonment, or hospitalization—and, for many, a repetition of the same cycle.

Some of the witnesses had been summoned from prisons or juvenile reform schools where they were inmates. Some came directly from hospitals where they were being treated for narcotic addiction. They ran the gamut of "dope slaves." They included:

A seventeen-year-old New York boy who started taking marihuana at thirteen, switched to heroin at fifteen, quit school to get a job, and became a burglar when he couldn't make the eight dollars a day he needed to buy heroin.

This pamphlet has been prepared by Albert Deutsch, noted social welfare writer, in cooperation with the Office of Public Health Education, State of New York Department of Health.

A twenty-year-old girl who stole government checks from mail boxes in order to buy the drug she needed in increasing amounts.

Another girl who became a streetwalker, spending all her earnings on heroin.

An ex-scoutmaster who had become a slave to the dope habit because of the "strain" of an incompatible marriage.

A girl who said she was started on the road to addiction by a boy friend who, an addict himself, gave her some dope to ease the pain of a stomach ailment.

A Chicago youth of eighteen who started smoking marihuana with many of his classmates when he was fifteen went onto heroin, and "walked off a countless number of jobs because of the habit."

The Senate hearings on the narcotics problem were but one of many official investigations—federal, state and local—launched as public anxiety intensified with increasing reports of an "epidemic of teen-age dope addiction." Periodic "dope racket" sensations had aroused the American people before, but never had emotions been stirred to such a pitch as by the accounts of teen-age drug addicts which made front-page news in the nation's press over a period of many months. Concern in many communities mounted to hysterical levels. Many laws were proposed and adopted to "stamp out the dope menace." Some of these hasty "cures" tended only to worsen the situation.

Facts Behind the Teen-Age Dope Scare

For years there had been a complacent feeling that the traffic in narcotics had been reduced to a small-size police problem. Now it was catapulted again into a major menace, threatening to poison the well-springs of the nation's youth. Health expert vied with police official in presenting figures—many of which have been challenged—indicating that narcotic addiction had reached epidemic proportions among teen-agers. Fear and even hysteria struck at the heart of many parents as they read these grave pronouncements about the rising tide of addiction.

The public alarm over the narcotics menace was touched off in 1950 by a series of scattered reports from medical and law-enforcement sources warning that big-scale teen-age addiction was spanning the nation. The most alarming single set of figures came from a U. S. Public Health Service official, who reported that the number of patients under twenty-one admitted to the two federal hospitals

for drug addicts—at Lexington, Kentucky, and Fort Worth, Texas—had mounted from 22 in 1947 to 440 in 1950—a rise of 2,000 per cent. A police officer in New York City created a sensation when he estimated, in the course of an inquiry into local narcotics traffic, that as many as fifteen hundred school children in the metropolis were using drugs. In June, 1951, Dr. Lois Higgins, director of the Crime Prevention Bureau in Chicago, revealed that narcotics-violation arrests of persons under twenty-one years of age in that city had jumped from 136 in 1948 to 1,017 in 1950. The total narcotic arrests for all ages during the same period, she added, had risen from 738 to 4,437.

A few days earlier, the Federal Grand Jury in Detroit handed up a presentment that stated:

> Your Grand Jurors report that conditions of the most shocking nature were revealed in the testimony adduced before them: that young people ranging in age between fourteen and twenty-one have become confirmed and inveterate users of heroin, morphine, and cocaine; that these young people, enslaved through their addiction to narcotics, resorted not only to thievery in the homes of their parents and relatives but became shoplifters and common thieves, and that many of the young girls became prostitutes, because of the necessity to purchase enough to satisfy the daily needs of their uncontrollable craving.

In April, 1951, the New York State Legislature ordered an official investigation into the narcotics racket. Attorney General Nathaniel L. Goldstein, after a state-wide inquiry, summed up his findings in a report submitted in January, 1952:

1. Narcotic use and addiction, with its attendant mental and physical degeneration, has increased in tremendous fashion since World War II, and particularly in the last two years.

2. The disease has spread with alarming rapidity through the ranks of our adolescent society.

3. Addiction has and will continue to bring about a sharp increase in juvenile delinquency and crime unless immediately and effectively checked.

These and many similar reports in various parts of the country kept agitating the public about the "teen-age dope menace." Bills were introduced in Congress and in many state legislatures making it a capital crime, punishable by death, to sell narcotics to minors. No state adopted this extreme measure, but laws were enacted pro-

viding stiff prison sentences for sellers and illicit possessors of such drugs. Official commissions and citizens' committees were set up in many communities to study the narcotics danger and to recommend means to combat it. School principals and teachers were hastily briefed on the problem and were given pointers on how to spot possible users among their pupils. Newspapers and magazines published lengthy series on the problem. Radio and television networks carried dramatic presentations, including tape-recorded autobiographies from the lips of adolescent addicts. In many cities, large-scale round-ups of narcotic suspects were conducted.

Follies and Excesses

The public concern was so intense as to approach panic at times, and occasionally led to follies and excesses. In one southwestern city where there was actually no narcotics problem, a well-intentioned but ill-informed civic organization adopted a resolution calling for a crusade against the dope menace in the local high schools. The resolution won headlines in the local press. The school superintendent calmly asked for particulars, pointing out that not a single case of drug addiction had ever been recorded among high school pupils in that community. No one could produce any evidence to the contrary. The flurry of excitement ended suddenly.

Many over-anxious parents hurried their children to physicians to be examined for possible addiction. Others took it for granted that addiction was rampant in every high school, including those attended by their own children. Adolescents completely innocent of any knowledge of the subject were consulted by adults for expert advice and inside information on narcotics. Over-alert school teachers, warned by their superiors to watch for signs of addiction, rushed pupils to clinics for inspection on no more grounds than that they appeared drowsy or listless. Some children, impressed by the glow of glamor that surrounded the subject of teen-age addiction, as described in the more sensational sections of the press and radio, pocked their arms with pin-pricks, then went about boasting they were "junkies," or addicts. One boy in New York City, coming home with a poor report card, made several pricks in his arm with a pin, calmly told his mother that he was a "junky," and was rushed by the hysterical parent to a hospital. When the hoax was discovered, the boy confessed he had perpetrated it in an effort to escape a spanking for the bad marks.

poppy, a plant grown mainly in India, China, Turkey, Iran, and Yugoslavia. It is usually smoked in a special pipe by addicts, sometimes eaten. Opium and its derivatives are used medically to relieve pain and to produce sleep; addicts use it to produce a dreamy, pleasant stupor.

American addicts seldom use opium, but there is a good-sized illicit traffic in its main derivatives—*morphine* and *heroin*. Both are powders, sold illicitly by peddlers mainly in capsules ("caps") or flat packets ("decks"). Both are powerfully addicting drugs. Heroin is considered worse than morphine, although at one time it was substituted for the latter as "non-addicting." Its manufacture and sale was prohibited by a federal law more than a quarter-century ago, and it is now available, except in very limited quantities, only on the illicit market.

Heroin is the most frequently used opiate among American addicts. It is taken either by sniffing through the nose ("snorting") or by injection with a hypodermic needle ("the main line").

Codeine and *dilaudid* ® are other opium derivatives sometimes prescribed by physicians to relieve pain which occasionally are sold on the illicit narcotic market.

Then there are several morphine-like drugs manufactured synthetically in chemical laboratories—*methadone* and *demerol* ® among them—which have the same sleep-producing and pain-relieving qualities of morphine. When first introduced on the medical market, these synthetic drugs were hailed as being non-addicting, but further study and use proved otherwise.

Marihuana, which is made from the leaves of a plant known as Cannabis Sativa and smoked in the form of cigarettes ("reefers," "sticks," "weeds"). The use of this plant is relatively new in the United States, although it has been eaten for centuries in India and other Eastern lands under the name of *hashish*. It has much the same effect as an alcoholic binge, usually causing the user to act silly, giggle, and to feel clever when he or she is really behaving ridiculously. It has become a special problem among jazz musicians, many of whom smoke marihuana in the belief that it makes them play "hotter," although scientific tests indicate that their musicianship actually declines under the marihuana influence, and that the players only *think* they are performing better.

The growth and sale of marihuana without license is forbidden by federal law and by that of many states. Most of it sold on the

illicit market is obtained from Mexico, though it grows wild in the United States and has been cultivated illegally.

Its use has spread rapidly in recent years in the entertainment field and in certain underprivileged sections of metropolitan areas, mainly because it is relatively cheap (a "reefer" can be bought from street peddlers for fifty cents to a dollar) and produces no "withdrawal symptoms" when a user stops smoking it. Nonetheless, it is a dangerous intoxicating drug on other scores, most particularly because many marihuana users "graduate" to heroin in order to get a bigger "kick" or "bang." It is the most widely used drug among teen-agers.

SLEEPING PILLS AND ALCOHOL

WE do not ordinarily think of sleeping pills or alcohol as narcotic drugs, but both fall technically into that category, and some health experts consider them the most dangerous of all habituating drugs—each a greater menace in America than morphine, heroin, cocaine, and marihuana combined. The principal peril in both lies in the fact that the lay public has not become sufficiently alert to the dangers inherent in the excessive use of these drugs. Too many Americans are using them too carelessly and too freely, and a large percentage of users are or have become dependent upon them. Experts estimate that there are several million chronic alcoholics, or addicts, in the United States, besides the many millions more who become intoxicated occasionally. No thorough-going program for meeting the narcotic problem in America can overlook the catastrophic consequences of alcohol addiction, in terms of the large-scale personal and family tragedy it produces, along with the serious community problems arising from crimes and accidents committed and caused by persons under the influence of liquor. Since alcoholism is generally treated as a separate medical and social problem, however, we shall omit further mention of it in this pamphlet.*

Barbiturates, derived from barbituric acid, are the basic ingredients of nearly all sleeping pills or capsules. Properly used on a physician's prescription, they are of incalculable value in the

*See *Alcoholism—A Sickness that Can Be Beaten,* by Alton L. Blakeslee, Public Affairs Pamphlet No. 118, 25 cents.

CAUSES

a hostile "lone wolf" incapable of attaching deep feeling toward anyone. In his discomfort, he may suffer pain—real or imaginary.

The ordinary human being has normal defense machinery with which to meet life's disappointments, frustrations, and conflicts. But the potential addict lacks enough of this inner strength to conquer his emotional problems and the anxiety they create. In a moment of stress, he may be introduced to narcotics as the "sure fire" answer to his needs. Experiencing relief from his pain, or an unreal flight from his problems, or a puffed-up sense of power and control regarding them, Mr. Addiction Prone is well on the road toward making narcotics his way of life. . . .

Although, as stated before, addiction runs through every class, the great majority of its victims live on the ragged edge of existence. Their weak personality structures buckle easily under the harsh realities of marginal life and they become easy marks for the drug habit. As the habit fixes itself upon them, they drift farther and farther from the challenges and opportunities of the everyday world. Unable to earn an honest livelihood because of their compelling, all consuming addiction, forced into constant contact with the crooked characters who supply their narcotic needs, they degenerate morally, descend into thievery and other law-breaking practices to obtain the ever increasing sums required to purchase their drugs, and wind up as denizens of the underworld. They are tragic misfits and failures, hunted and haunted, outcasts from normal society, with their goals reduced to a single essential—to get the drug that provides a transitory escape from life, at whatever cost.

THE TEEN-AGE ADDICTS

NOT long ago some medical men specializing in the study and treatment of narcotic addiction minimized the problem of marihuana. They pointed out that this weed, mainly smuggled in from Mexico, has about the same potency as alcohol, is not addicting in the physical sense of creating withdrawal symptoms when its use is stopped, and does not develop a craving.

What they didn't realize at the time—and what they are painfully aware of now—is that marihuana, especially among younger people, has become a stepping stone to the use of far more dangerous drugs. The teen-ager who starts on marihuana readily becomes

a candidate for heroin or morphine addiction in the hope of getting a bigger kick. Therein lies the most dangerous aspect of marihuana today—a dragnet for catching potential addicts and pushing them on to the really dangerous drugs.

Figures compiled by the U. S. Public Health Service Hospital at Lexington show that in 1950, at the height of the "teen-age addiction epidemic," more than two-thirds of all patients under twenty-one came from three cities—New York, Washington and Chicago.

The available studies reveal that the great bulk of teen-age drug addiction occurs in the slum areas of large cities—areas where life is bleak, where wholesome outlets for adolescent energies and drives are meager, where community rot makes fertile soil for family and personal disorganization, where flat monotonous routines within the circumscribed spheres of living enhance the desire to seek escape by various unconventional methods, antisocial and otherwise.

The same studies also show that the number of Negro and other minority-group children among teen-age addicts is highly disproportionate to their total in the general population. No one can be certain just why this is so. One factor may be the prevalence of marihuana smoking among jazz musicians and other popular entertainers. These include both whites and Negroes, but it so happens that some of the Negroes are heroes to the teen-agers of their race. But the major factors undoubtedly must be sought in the slum environment, the ghettoed life of most Negro communities, the restricted opportunities of Negro children, the pent-up resentments against discrimination, and the intensified sense of futility and frustration found in all minority groups burdened with the double weight of poverty and discrimination.

The fact that teen-age drug addiction today occurs mainly in slums is no guarantee that it might not spread like wildfire through all classes of adolescents if vigilance were relaxed. For addiction acts like a communicable disease among teen-agers as it does among adults. Contagion may spread by contact through all sections of the population. As with all communicable diseases, attention must be concentrated on the main points of infection if the rest of the population is to be protected.

The following excerpts from testimony from youthful addicts before the U. S. Senate Crime Investigating Committee present a graphic picture of the start, course, and consequences of the evil.

A seventeen-year-old New York City lad, then being treated for addiction, testified:

THE CHAIRMAN: How long have you been on narcotics?
THE WITNESS: Two and a half years.

Did you finish schooling (high school)?
No.

Why did you leave?
I left because of drugs.

What kind of drugs?
Heroin.

You used reefers before that?
Yes, sir.

Why did you use reefers?
For the fun of it.

How old were you when you started using reefers?
About thirteen or fourteen.

How many children of your age did you know roughly, who were using marihuana?
Fifty or a hundred.

Did you usually use marihuana on your own or in groups?
In groups.

How did you happen to get started on heroin?
A fellow offered it to me.

A friend of yours?
Yes.

Did you find when you were a snorter (heroin-sniffer) that you wanted more?
The more I had the more I wanted.

You kept on increasing it?
Yes, sir.

Did you leave school so that you could get the money to buy the drugs with? (The boy had testified he spent about $8 a day for heroin.)
Yes.

Do you know of any children who have been killed by overdoses?
Yes, two or three of them.

Just from not knowing how much they were taking?
No. Sometimes they (the peddlers) would give them poison in the capsules. One of them died from an overdose.

Did you have any trouble keeping a job?
Yes, when I used to get sick (withdrawal symptoms), when I couldn't get the stuff.

You sometimes would steal from your mother, and steal things around the house?
Yes, anything.

Now, you knew a lot of other children using narcotics who were not working, didn't you?
Yes.

What did they do in order to get money?
They used to rob it.

You got in with some of the parties that burglarized places?
Yes.

Would you have done any of these things if you had not needed the money for these drugs?
That was the only reason.

HOW THE NARCOTICS TRAFFIC WORKS

THE narcotics traffic is essentially a global problem. The problem could be solved if the growth, manufacture, and distribution of narcotics could be strictly limited to the amounts known to be needed for medicinal and research purposes. Since 1912 efforts at international control of the traffic have been made through compacts, through the League of Nations, and more recently through the United Nations. These international accords have succeeded in greatly reducing the sources of narcotics supply, but there are many blocks in the way of universal suppression of illicit traffic.

In some countries—notably those that are the greatest producers of plants from which narcotic drugs are derived—there are no laws against selling or using narcotics, or else the laws are so poorly enforced as to be virtually inoperable. For instance, in some lands opium smoking and eating is tolerated in much the same way that we tolerate the imbibing of alcoholic beverages. Chewing coca leaves is more or less common in several South American countries where this source of cocaine is produced.

It is estimated that 2,000 tons of opium are produced annually, whereas the amount needed for legitimate medicinal and research purposes throughout the world totals only about 450 tons a year. Countries like Italy, Turkey, and Greece manufacture many times more the amounts of morphine and heroin (opium derivatives) than they need for domestic consumption or legitimate export. The bulk of these manufactured narcotics finds its way into illicit international traffic, and much of it reaches the shores of the United States, where the dope racketeers bid highest for the "goods."

The legal world-wide price of opium is fixed at ten dollars a pound. The opium poppy farmer who sells his product on the black market gets at least twice the price. Then it passes through many hands as it moves along the lines of illicit traffic, jumping in price with each transaction. When heroin, derived from the raw opium, finally reaches the outstretched hands of addicts, the estimated price is equivalent to about $48,000 a pound!

So long as the fantastic profits in narcotics remain as a lure to racketeers, big-time and small-time, so long will there be men of easy conscience ready to participate in the cutting of the pie.

At the top of the racketeering heap are the international smuggling rings which organize and operate the complicated mechanisms that channel the narcotics traffic from primary producer to ultimate user. Along the way, the stream of narcotics distribution is smoothed in many areas by bribery and corruption of government officials. Subsidies paid to persons who appear as casual traffickers enhance the distribution of the drugs.

The smuggling devices are many and devious; professional experts ply this trade, together with seamen tempted by the big money. Once in this country, the narcotics percolate through a hierarchy of big-shot racketeers operating on a nation-wide scale, through various levels of middlemen, down to the neighborhood peddler who sells his wares on street-corners, in back-alleys and dingy stores. It has been reported that competing dope peddlers—in some areas—parcel out specific areas of operation, fix prices, and pool finances for "mutual protection" in the form of police bribes.

MOBILIZING FOR DRUG CONTROL

INTERNATIONAL, national, state, and local bulwarks have gradually been built up to suppress this illicit traffic. Let us examine briefly the main defenses against narcotic drugs.

United Nations

The UN has two agencies devoted to the regulation of lawful international traffic in narcotics and the suppression of illicit traffic. The UN Permanent Central Opium Board seeks to assess the legitimate medical and research needs for opium and its derivatives throughout the world. The UN Commission on Narcotic Drugs, an agency of the UN's Economic and Social Council, tries to keep

added law enforcement problem. A still greater problem, potentially, is implicit in the news that medical scientists are nearing the successful synthesis, on a commercial basis, of morphine itself. If and when this is attained, even the eradication of all opium-growing on the face of the earth would still leave us with a major opiate-equivalent problem, because no narcotic has been discovered or developed in a laboratory that is inherently free of addicting powers, nor is one likely to be found.

An effective federal curb on a powerful group of addicting drugs not covered by the Harrison Narcotics Act was made possible in 1951 when Congress enacted the Durham-Humphrey Act, prohibiting the sale of barbiturate drugs (sleeping pills) without a physician's prescription, covering the nation with a restriction already imposed by many, but not all, states.

THE MEDICAL ATTACK ON NARCOTICS

ONE of the most favorable results of the recent interest in narcotics is the widening recognition that, although suppression of the illicit traffic is mainly a law enforcement problem, drug addiction itself is a social-medical problem. While new federal and state laws increased the severity of penalties against traffickers in narcotics, public concern for their youthful victims led to enlightened measures aimed at rehabilitating addicts. The social benefits of providing effective treatment for the individual addict have not been overlooked. There is, for instance, a growing recognition that successful restoration of a drug addict erases one more focus of infection.

This realization leads quite properly to the question: Can addiction really be cured? It can, say our leading authorities. It is true that a very large percentage of addicts who take the "cure," voluntarily or unwillingly, at public hospitals and private sanatoria, back-slide into addiction. But many are successfully rehabilitated. Further, it is now known that the process of "curing" an addict has usually been too limited in time and effort. The new knowledge, now available, promises a far more impressive score of permanent cures.

What are our available facilities for treating addicts, and how are they used?

Federal Facilities

The largest and by far the best known institution for the special treatment of men and women who are addicted to narcotic drugs is the U. S. Public Health Service Hospital at Lexington with 1,300 beds. It cannot accept barbiturate addicts or alcoholics unless they are also addicted to one of the aforementioned drugs. In 1951 this hospital established special wards for adolescent addicts.

A second federal institution for treating drug addicts is the U. S. Public Health Service Hospital at Fort Worth, Texas, which has approximately 500 beds for narcotic addicts. The Fort Worth institution takes in only male patients. Both federal narcotic hospital facilities admit addicts convicted and sentenced by federal courts, those placed on probation as narcotics-law violators on condition that they be treated in a hospital, and also patients who voluntarily apply for admission. The hospitals give free treatment to patients who can't afford to pay, and charge others five dollars a day—a fee far below actual cost.

Addicts or their relatives seeking information on how to apply for federal hospital treatment should write the Surgeon General of the U. S. Public Health Service, Washington 25, D. C., or to the medical officer-in-charge of the U. S. Public Health Service Hospital at either Lexington, Kentucky, or Fort Worth, Texas.

The "voluntary" patient poses a serious problem for the federal hospitals, as well as for other public and private institutions. A great deal of will power is required to pass through the first phase of treatment—the gradual withdrawal of the patient from dependence on the addicting drug—and relatively few can "take it" without some element of compulsion being present. Since there is no legal way of keeping voluntary patients against their will, many leave before going through the course and quickly relapse to "the habit" when they return to the community. Others who stick through the withdrawal phase tend to consider themselves cured before other necessary phases of treatment are passed through, and likewise become apt candidates for relapse into addiction.

Not long ago the State of Kentucky enacted the so-called "Blue Grass Law," specifically intended to give some assurance that the "voluntary" patient will go through the full course of treatment. Under this law, a narcotic addict may go directly to the police chief of Lexington, Kentucky or to the U. S. Bureau of Narcotics

support and actively urge adequate Congressional appropriations toward that end. Perhaps another federal hospital or two should be established to bring such facilities closer to communities where addiction flourishes. It would be a mistake, however, to insist on setting up a large number of local clinics for addicts for two main reasons. The treatment of addiction requires teams of well-trained experts not readily available in most localities. Also needed are carefully designed and equipped facilities for handling this difficult and complex disease.

Together with improvement in our treatment facilities, we need to expand and intensify scientific research into the causes, cure, and prevention of drug addiction. Our scientists need to know more, for instance, about why so many addicts relapse after undergoing curative treatment. They need to know more about why certain individuals become addicts and others don't, even after experimenting with narcotics. As citizens, we can support measures on all governmental levels to aid scientific narcotic research, and also support private research centers.

Addicts Anonymous

In 1947 an organization patterned after Alcoholics Anonymous was founded by patients of the federal hospital at Lexington. The founders called it Addicts Anonymous, and got help in getting started from members of an Alcoholics Anonymous chapter in a nearby town. The organization has the same basic principles of mutual help in warding off the threat of relapse governing the original AA group, which has scored impressive successes in saving many former alcoholics from falling off the wagon. Chapters of Addicts Anonymous have been established in several large cities. All ex-addicts are welcomed as members. So far, the results have been most promising.

Alcohol and Barbiturates

As noted earlier, no anti-narcotics program can be complete without unceasing and strengthened activities against the menace of excessive use of alcohol, sleeping pills, and lesser drugs that are habit-forming. Particularly needed is a more intensified program of public education on the tragic consequences that follow abuse of these drugs, together with more stringent curbs to check the wide-scale excessive use that constitutes a grave social danger.

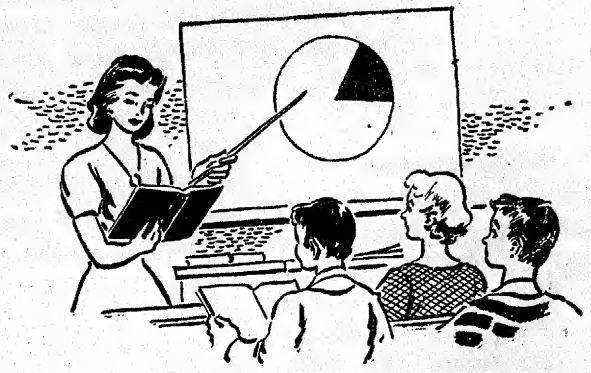
Local Action

The panicky and often ill-considered action that arose in some communities during the height of the so-called "teen-age epidemic" points up the lesson that the best steps to stamp out addiction among adolescents and older people are invariably based on sober surveys of existing conditions. The problem varies widely in different communities, and action should be founded on the extent and potential threat of addiction in the particular locality. No blueprint for action can possibly fit all areas. In all cases, local action should be based on solid information and should be linked to existing state and national programs.

Parents should be apprised soberly of the available facts concerning narcotic addiction, without spreading undue alarm or panic.

Action in Schools

Most states have laws requiring the teaching of facts about narcotics in the educational system. It is generally agreed that for children special courses on narcotic addiction are not desirable. It is best to have the facts fall naturally within a regular course on health, hygiene, science, or other subjects. In all cases where addiction is a serious local problem, school teachers should be instructed in the elementary facts, as well as in the techniques of transmitting this knowledge to their pupils. The problem of education in drug addiction is a delicate and difficult one. The UN



Commission on Narcotics, not long ago, adopted a resolution opposing special public educational programs in narcotics as "dangerous." Public education among children and adults, if unwisely or improperly conducted, can do far more harm than good, in that a poor program may only glamorize the subject.

The New York City Board of Education has prepared and circulated an excellent pamphlet entitled "Suggestions for Teaching the Nature and Effects of Narcotics for Use in Grades 7–12" that could serve as a handy guide for school staffs in other metropolitan areas where the teen-age addiction problem is acute. Many states have prepared similar materials on narcotic control.

Social Approach

Finally, we return to the fundamental point that, while addiction strikes every economic and social class, it is found most extensively and most devastatingly in the poverty-stricken areas of large cities. The problem, in the large, cannot be divorced from the constellation of broad social and health problems found in our slum districts, and especially in those peopled by members of underprivileged minority groups.

We can never hope to eradicate all drug addiction by abolishing the slums, by providing equality of opportunity for all groups in our population, by developing wholesome substitutes for gang activities among slum-bound adolescents, by easing group tensions that so often are a factor in emotional instability and insecurity, by making life challenging enough to render escape through dream-giving drugs less alluring—but this broad approach may prove to be the most effective method of community action against addiction, teen-age and otherwise, as well as against juvenile delinquency and other "diseases of privation."

We need not dream up Utopias in our attack on the narcotics evil. We can dare to set ourselves the democratic goals of fair play and equal opportunity for all, to seek to establish such minimum standards of life for all that none would seek escape at the hazard of life and health.

WHAT TO READ

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